

**MEDICAL RECORDS RELEASE AUTHORIZATION**

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

I hereby authorize and request that my medical records be released:

To Dr. Quinn       From Dr. Quinn

Office Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**RECORDS REQUESTED**

- All Relevant Records
- Audiogram
- Recent Lab Work, X-Rays, Pathology Reports, Other Reports
- Allergy Skin Test, Rast Test, Allergy Vaccine Contents/Formula
- Other \_\_\_\_\_

**INSTRUCTIONS**

- Please FAX records to (704) 782-6605 ASAP
- Urgent - Patient is waiting to be seen by the Doctor
- Please mail records to 25 Lake Concord Rd., Concord NC 28025

I hereby confirm that I have legal authority to sign this Release form to obtain records

Signature \_\_\_\_\_ Date \_\_\_\_\_

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